STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 01 B. WING	05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/17/12 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Provena Sacred Heart Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The orginal building consisting of the St. Anthony, St. Claire, St. Paul, and the St. Frances neighborhood as well as the main dining room, chapel and service hall was surveyed with Chapter 19, Existing	K0000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Provena Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Provena Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Health Care Occupancies This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 133 and had a census of 122 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/22/12. This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0014 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 8 of 9 corridors in the facility. This deficient practice could affect all occupants except those on H hall. Findings include: Based on observations with the Property Manager on 05/17/12 during the tour from 12:45 p.m. to 3:20 p.m., carpet was installed on the bottom one third of all corridor walls with the exception of the H hall. Based on an interview with the Administrator during the exit interview at 3:55 p.m., documentation was available to demonstrate the carpet had a Class I fire spread rating and not a flame spread rating of Class A or Class B. Based on an interview with the Property Manager at this	K0014	Carpeting on the bottom third of all corridor walls with the exception of the H hall has been treated by a chemical to provide a Class A or Class B flame spread rating. Property Manager will retain the documentation of the chemical used and the Class flame rating for the carpeting. Property Manager is responsible. Property Manager will monitor.	06/15/2012

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	time, he has not treated the carpet with a chemical to provide a Class A or Class B flame spread rating. 3.1-19(b)			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 2 clean linen closet corridor doors and 1 of 1 treatment room corridor doors closed and latched into the door frame. This deficient practice could affect any residents near the St. Paul and St. Clair clean linen closets and the St. Clair treatment room in the event of an emergency. Findings include: Based on observations with the Property Manager on 05/17/12 during the tour from 12:03 p.m. to 3:20 p.m., the following corridor doors lacked latching	K0018	Installed latching mechanisms so door latches into door frame for corridor clean linen closet doors on St. Paul & St. Clare and the St. Clare treatment room corridor door. Maintenance to monitor weekly for compliance, see Neighborhood Environmental Checklist form "Corridor dors latch, self-closing devices operating" included and monitored by quality assurance on-gong on a monthly basis. The Property Manager is responsible. Property Manager will monitor.	06/15/2012

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	hardware and failed to latch into the door frame: the St. Paul and St. Clair clean linen closets and the St. Clair treatment room. This was acknowledged by the Property Manager at the time of observation. 3.1-19(b)			

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5			
	Based on observation and interview, the facility failed to ensure 2 of 2 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any residents near doors leading to assisted living from health care. Findings include: Based on observation with the Property Manager on 05/17/12 at 3:20 p.m., both sets of fire doors leading into the assisted living from health care did not latch into the frame when the fire alarm was	K0044	Latching mechanisms installed on both sets of fire doors leading into the assisted living from the SNF so doors latch into the frame when fire alarm is activated. Maintenance to monitor quarterly 1 time per shift and on-going as added to Fire Alarm/Fire Drill Report form Section II. Life Safety #5 "Did the Fire Doors close and latch into door frame?" see form included. Property Manager is responsible. Property Manager to monitor.	06/15/2012

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	activated. Based on an interview with the Property Manager at the time of observation, the door sets will only latch when approached by a resident with a wonder guard device. 3.1-19(b)			

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K0052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation with the Maintenance Supervisor on 08/29/11 at 1:12 p.m., the main fire alarm panel is located in the electrical/mechanical room located in the service hall which was not continually occupied therefore a trouble signal could	K0052	Fire alarm annunciator panel installed in the St. Anthony Neighborhood Nursing Station area that is manned 24/7. In-service training is provided to nursing staff about proper actions and responses to fire alarm panel notifications. Maintenance will monitor on a quarterly basis, 1 time per shift for proper operation of annunciator panel, added to fire alarm/ Fire Drill Report form # 10 in Section II Life Safety "Did Annunciator Panel activate?" and #10 in Section IV Staff Knowledge Questions "Is staff aware of Annunciator Panel?" See form included. Property Manager is responsible. Property Manager to monitor.	06/15/2012

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	not be heard in this location at all times. The facility does not have an annunciator panel for the fire alarm system. Based on an interview with the Maintenance Supervisor at the time of observation, the service hall is not occupied continuously. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 4 of 4 electrical rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry type electrical equipment is used. (c) Equipment is installed in a 2 hour fire rated enclosure including protection for penetrations. (d) No combustible storage is	K0056	All combustible items removed from all electrical rooms, no combustible storage permitted as of 5-24-12. Maintenance to monitor weekly for complaince, see Neighborhood Environmental Checklist Electrical Rooms: "service panel unobstructed, no combustible items" form included and monitored by quality assurance on-going on a monthly basis. Property Manager responsible.Self closing device installed on the corridor door to St. Clare north exit electrical room. Maintenance to monitor weekly for compliance, see Neighborhood environmental checklist, monitored by quality assurance on-going on a monthly basis. Property Manager responsible. 2 of 7 sprinkler heads in HR office, 2 of 19 sprinkler heads in the St. Paul dining room and 2 of 19 sprinkler heads in St. Paul lounge will	06/15/2012

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	permitted to be stored in the room. This deficient practice could affect any residents near the electrical rooms located in the St. Clair, St. Paul and St. Anthony neighborhoods and in the St. Clair north exit area. Findings include: Based on an observations with the Property Manager on 05/17/12 from 1:00 p.m. to 2:35 p.m., the following electrical rooms within a two hour fire rated enclosure are not sprinklered and each electrical room on St. Clair, St. Paul and St. Anthony is being used to store a trash barrel of biohazardous waste and a large plastic container, measuring one half cubic yard, full of trash. The St. Anthony electrical room had a one quart size metal container of charcoal lighter fluid. Additionally, the self closing device on the corridor door to the St. Clair north exit electrical room had been removed and the door did not self close. 3.1-19(b) 2. Based on observation and		be relocated by 6-15-12 to be separated by at least 6 feet. Upon further inspection to prevent other residents from having the potential to be affected by the same deficient practice 21 sprinkler heads through out the building will be relocated to be separated by at least 6 feet by 6-15-2012. Property Manager is responsible. Property Manager will monitor. The sprinkler system will be extended to provide sprinkler coverage to the service hall housekeeping chemical storage room by 6-15-12. Property Manaager will arrange for sprinkler coverage work to be performed and supervise. Property Manager is responsbile. Property Manager will monitor.	

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	interview, the facility failed to ensure 2 of 7 sprinkler heads in the Human Resources office, 2 of 19 sprinkler heads in the St. Paul dining room and 2 of 19 sprinkler heads in the St. Paul Lounge were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the St. Paul dining room and the St. Paul lounge and any staff in the Human Resource office in the event of a fire emergency. Findings include: Based on observations with the Property Manager on 05/17/12 from 12:45 p.m. and 1:50 p.m., the following was noted regarding the sprinkler heads: a. in the Human Resource office, the two sprinkler heads above the weight scales were located sixty five inches apart b. the west side of the St. Anthony dining room had two sprinkler heads located sixty five inches apart			

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	c. the west side of the St. Paul lounge had two sprinkler heads located thirty eight inches apart. This was acknowledged by the Property Manager at the time of observations. Measurements were provided by the Property Manager at the time of observations. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure complete coverage was provided for 1 of 1 housekeeping chemical storage rooms in the service hall in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect any resident evacuated through the service hall. Findings include: Based on an observation with the Property Manager on 05/17/12 at 2:55 p.m., the service hall housekeeping chemical storage room lacked sprinkler coverage. This was acknowledged by the			

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	Property Manager at the time of observations. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants in the existing portions of the building. Findings include: Based on review of the generator log titled "Weekly Checks for Generator Log" with the Property Manager on 05/17/12 at 11:51 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not	K0144	Weekly Checks for Generator Log form will include the monthly load test time for the transfer of power from the main source to the generator. Property Manager will retain documentation of generator testing, Q/A to review monthly and on-going to confirm load test for transfer of power from the main source to the generator. The Property Manager is responsible. Property Manager to monitor.	06/15/2012

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	include the time for the transfer of power from the main source to the generator since November 2011. This was acknowledged by the Property Manager. 3.1-19(b)			

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/17/12 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Provena Sacred Heart Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new section of the building consisting of the H wing was surveyed with Chapter 18, New Health Care Occupancies This one story facility with a partial basement was determined	K0000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Provena Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Provena Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 03 B. WING	05/17/2012

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	to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 133 and had a census of 122 at the time of this survey. This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING _____ B. WING 03	05/17/2012

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants in the new portions of the building. Findings include: Based on review of the generator log titled "Weekly Checks for Generator Log" with the Property Manager on 05/17/12 at 11:51 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not	K0144	Weekly Checks for Generator Log form will include the monthly load test time for the transfer of power from the main source to the generator. Property Manager will retain documentation of generator testing, Q/A to review monthly and on-going to confirm load test for transfer of power from the main source to the generator. The Property Manager is responsible. Property Manager to monitor.	06/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 03 B. WING	05/17/2012

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	include the time for the transfer of power from the main source to the generator since November 2011. This was acknowledged by the Property Manager. 3.1-19(b)			